DRS. CASSINELLI & SHANKER

SPECIALISTS IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS

7242 TYLERS CORNER DRIVE
WEST CHESTER, OHIO 45069
(513)777-7060
www.westchesterortho.com

PRE-AUTHORIZED HEALTH CARE FORM

I AUTHORIZE DRS. CASSINELLI AND SHANKER TO KEEP MY SIGNATURE ON FILE AND TO CHARGE MY _____ ACCOUNT FOR:
VISA, MASTERCARD, DISCOVER, AMEX

RECURRING CHARGES (ON-GOING TREATMENTS) OF $_____

EVERY_____ FROM_____TO _____
(FREQUENCY) (MONTH/YEAR) (MONTH/YEAR)

TO OCCUR ON OR ABOUT THE 18TH OF EACH MONTH.

I UNDERSTAND THAT THIS FORM IS VALID UNTIL_____ UNLESS I CANCEL THROUGH WRITTEN NOTICE TO THE HEALTH CARE PROVIDER.

PATIENT NAME

CARDHOLDER NAME

CARDHOLDER ADDRESS

CITY **STATE** **ZIP**

CREDIT CARD ACCOUNT NUMER **EXPIRATION DATE** **SECURITY CODE**

CARDHOLDER SIGNATURE **DATE**